Provider Profile and Enrollment

Physician:_____
Last First MI Title

Clinic Name:_____

Type of Facility:
- ☐ A. Public Health Department
- ☐ B. Public Hospital
- ☐ C. Private Practice (Individual or Group)
- ☐ D. Private Hospital
- ☐ E. Federally Qualified Health Center (FQHC)
- ☐ F. Certified Rural Health Clinic (RHC)
- ☐ G. Other Facility _____

Note: If claiming FQHC or RHC status, you must be Federally certified.

Contact Person: _____
First Last Title

Vaccine Delivery Address:_____
Street Only (No P.O. Boxes)

_____ _____ _____
City State Zip

Mailing Address:_____
Street or PO Box

_____ _____ _____
City State Zip

Email Address:_____

Telephone: ( ) _____ Extension_____ **Fax:** ( )_____

Days and Times Vaccine May be Delivered: Tues. _____AM to_____PM Wed. _____AM to_____PM
Thurs. _____AM to_____PM Fri. _____AM to_____PM

Note: Please Notify the Utah VFC Program if this schedule changes (vacation, closure, etc.)

PART I: Provider Enrollment

To participate in the Utah Vaccines for Children (VFC) Program and receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

1. I will screen patients and administer VFC program-purchased vaccine only to a child (≤18 years of age) who qualifies under one or more of the following categories: a) Is an American Indian or Alaskan Native; b) Is on Medicaid (or qualified through a State Medicaid waiver); c) Has no health insurance; or d) Has health insurance that does not pay for the vaccine (under-insured).

2. I will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP). (The ACIP Schedule is compatible with the AAP recommendations.)

3. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the ACIP, unless a) in my medical judgement, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the parent/guardian claims exemption to immunizations in accordance with the *Immunization Rule for Students* (R396-100).

4. I will maintain parent/guardian responses on the Patient Eligibility Screening Record form for a period of 7 years. Release of such records will be bound by the privacy protection of the federal Medicaid law.

5. If requested, I will make such records available to the Utah Department of Health or the Department of Health and Human Services (DHHS).

6. I will distribute written Vaccine Information Statements (VIS) and maintain records in accordance with the National Childhood Vaccine Injury Act.

7. I will not impose a charge for the cost of the vaccine.

8. I will not impose a charge for the administration of the vaccine that is higher than $10.50, the maximum fee established by the State of Utah and Medicaid.

9. I will not deny administration of a federally procured vaccine to a child because the child's parent/guardian/individual of record is unable to pay the administration fee.

10. I will comply with the State's requirements for ordering vaccine, and the quarterly submission of the Utah VFC Doses Administered Report.

11. I will develop and update a policy on the storage, handling, and transport of vaccines; implement a vaccine emergency handling procedure and review with staff annually.

12. The State may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.

13. I will be responsible for returning all public purchased vaccines to the State in accordance with State instructions.

_____ _____ _____

Print Name Signature Date

Medicaid Provider Number: _____ Medical License Number: _____

PART II: Provider Profile

Note: The following projections of children you will serve in the coming year must be based on data. Please document the data source for this information in the boxes provided.

A. For the 12 mo. period beginning 01/01/2002 project the number of children who will receive vaccinations at your health facility, by age group.

Numbers of all children(VFC & non-VFC) who will receive vaccine in the coming year:	<1 Year Old	1-6 Years	7-18 Years	Total
	a.	b.	c.	d.

B. Of the total number for each age group entered above, how many children are expected to be VFC eligible and under-insured, by category?

	<1 Year	1-6 Years	7-18 Years	Total
VFC - Enrolled in Medicaid				
VFC - No health insurance				
VFC - Am. Indian/Alaskan Nat.				
Under-insured				
Total				

Provider Profile (continued)

C. Of the total number of children in your practice, how many will be CHIP eligible?

	<1 Year Old	1-6 Years	7-18 Years	Total
CHIP	a.	b.	c.	d.

Type of data used to determine projections:

- ☐ A. Benchmarking Data
- ☐ B. Medicaid Claims Data
- ☐ C. Provider Encounter Data
- ☐ D. Registry Data
- ☐ E. Other_____ (Specify)

PART III: Provider Information

Please print or type the names and medical license numbers of the other health providers who may administer vaccine. It is not necessary to include the names of all staff who may administer vaccine, but rather, only those who possess a medical license or are authorized to write prescriptions.

Last Name, First, MI	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Medicaid Provider No. / Medical License No.	Specialty Peds, Family Med, GP, Other (specify)

Provider Information (continued)

Last Name, First, MI	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Medicaid Provider No. / Medical License No.	Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)
______________________ Last Name, First, MI	______________________ Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	______________________ Medicaid Provider No. ______________________ Medical License No.	______________ Specialty Peds, Family Med, GP, Other (specify)

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program, and must be updated yearly.

For State Use Only (enter date in only one box):

Date Certified for VFC: ☐☐/☐☐/☐☐☐☐ M M D D Y Y Y Y	Date Certified for VFC and Other Vaccine Purchased Under a Federal Contract ☐☐/☐☐/☐☐☐☐ M M D D Y Y Y Y
Date Updated for VFC: ☐☐/☐☐/☐☐☐☐ M M D D Y Y Y Y	**VFC PIN #** ________________

Please Mail Form to:

Utah Department of Health
Immunization Program
PO Box 142001
Salt Lake City, UT 84114-2001
Phone: (801) 538-9450
Fax: (801) 538-9440

VFC Form 1 11/01